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ABSTRACT

This opening chapter provides an overview of the book, "Healthy Children 2010: Establishing Preventive Services." The article describes the purpose of the work, which is to provide strategies to establish and successfully implement effective prevention services in key socializing settings that powerfully affect the growth an development of children. As a whole, the work emphasizes developmentally and contextually appropriate prevention service delivery models, and identifies state-of-the-art, empirically based strategies to strengthen the environments in which children develop. The article then describes the work's subsequent chapters: chapters 2 to 6 review ways to strengthen the family, child care systems, early childhood education, school-based mental health service delivery and primary prevention approaches, community-based mental health programming, and school-based health services. These chapters point out that programs with strong conceptualization, design, and implementation have potential to enhance children's social, emotional, and physical wellness, thereby reducing the incidence of problems across multiple domains. Chapter 7 focuses on the importance of theory-guided evaluation to clarify the process of program implementation, the extent of program outcomes, and the factors that enhance or diminish program effects. Chapters 8 and 9 emphasize the quality of program implementation as a critical mediator of potential program impact and highlight strategies to disseminate programs broadly while maintaining their efficacy. (SD)

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Introduction and Overview: Prevention Services—From Optimistic Promise to Widespread, Effective Practice

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There is tremendous optimism and enthusiasm for the promise of prevention. Although there have been tangible accomplishments—especially during the past two decades—in prevention research and practice, there is also the realistic recognition that much remains to be achieved (Institute of Medicine, 1994; Weissberg & Greenberg, 1997). The chapters in this book elaborate on three central themes regarding future efforts to establish effective, enduring prevention services for our nation's children and youth. First, scientists, practitioners, and policymakers must collaborate to diversify the portfolio of coordinated family-, school-, and community-based prevention services and strategies (see Chapters 2 to 6). Second, rigorous evaluations of prevention programs are critical both to document their efficacy and to identify ways to improve their quality (see Chapter 7). Third, because the positive effect of well-conceptualized and well-designed prevention programs is diminished when they are ineffectively conducted, it is important to attend to implementation quality—especially as programs are disseminated on a widespread basis (see Chapters 8 and 9).

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Concurrently with this volume, Sage has published Volume 8, *Healthy Children 2010: Enhancing Children's Wellness* (Weissberg, Gullotta, Hampton, Ryan, & Adams, 1997). *Enhancing Children's Wellness* presents recommendations to improve children's health status by the year 2010 in the following categorical areas: drug abuse (Dusenbury & Falco, 1997); high-risk sexual behavior, sexually transmitted diseases, and pregnancy (Sagrestano & Paikoff, 1997); violence (Murray, Guerra, & Williams, 1997); depression (Compas, Connor, & Wadsworth, 1997); suicide (Kalafat, 1997); nutrition (Perry, Lytle, & Story, 1997); unintentional injuries (Tuchfarber, Zins, & Jason, 1997); and academic performance (Hawkins, 1997).

The authors in *Enhancing Children's Wellness* provided integrative analyses of the latest research-based prevention and health promotion practices in their categorical topic area. Beyond that, they reinforced several themes highlighted in the book's first two chapters that reviewed common findings across multiple domains of problem behavior (Dryfoos, 1997; Weissberg & Kuster, 1997). First, these social, emotional, and behavioral problems often co-occur in the same individuals. Second, common family-, school-, and community-based risk and protective factors influence the development of varied social and health problems. Third, as Dryfoos (1997) concluded, we need to move beyond short-term categorical prevention efforts to comprehensive, multiyear approaches that address the social and psychological environment that gives rise to these problems. In this way we can affect tangibly the large numbers of young people experiencing social and health problems.

The current volume, *Healthy Children 2010: Establishing Preventive Services*, provides strategies to establish and successfully implement coordinated, effective prevention services in key socializing settings that powerfully affect the growth and development of children. Emphasizing developmentally and contextually appropriate prevention service delivery models, the authors identify state-of-the-art, empirically based strategies to strengthen the environments in which children develop.

Chapters 2 to 6 review ways to strengthen the family, child care systems, early childhood education, school-based mental health service delivery and primary prevention approaches, community-based mental health programming, and school-based health services. Programs with strong conceptualization, design, and implementation have potential to enhance children's social, emotional, and physical wellness, thereby reducing the incidence of problems across multiple domains (Weissberg & Greenberg, 1997). Chapter 7 reminds us of the importance of theory-guided evaluation to clarify the process of program implementation, the extent of program outcomes, and the factors that enhance or diminish program effects. Chapters 8 and 9 emphasize that quality of program implementation is a critical mediator of potential program impact, and these chapters highlight strategies to disseminate programs broadly while maintaining their efficacy.

Why *Healthy People 2010* Objectives Must Become a National Priority

As the year 2010 approaches, there is growing national concern about the large number of young people who engage in risk behaviors for negative social, emotional, and physical health outcomes such as drug abuse, teen pregnancy, AIDS, delinquency, depression, school dropout, and suicide (U.S. Department of Health and Human Services, Public Health Service [DHHS], 1991). Dryfoos (1990) estimated that 25% of American youth engage in multiple social and health risk behaviors, and an additional 25% experiment with some risk behaviors. The remaining 50%, who currently do not engage in such behavior, may nonetheless need effective education and consistent support to avoid such involvement. More recently, Dryfoos (1997) estimated that 30% of 14- to 17-year-olds engage in multiple problem behaviors that place them at high risk of extremely negative consequences, and about 35% are experimenting with various risky activities that jeopardize their futures.

Today's young people face greater risks to their current and future health and social development than ever before (Carnegie Council on Adolescent Development, 1995). American children and youth are smoking, drinking, having sex, committing violence, and becoming involved with gangs at younger and younger ages (National Commission on the Role of the School and the Community in Improving Adolescent Health, 1990). The social and health problems of America's children and youth are caused, to a

large extent, by significant changes that have occurred in families, schools, neighborhoods, and the media during the past few decades. Major social-environmental changes include dramatic alterations in family composition and stability, the breakdown of traditional neighborhoods and extended families, reduced amounts of meaningful and supportive personal contact between young people and positive adult role models, the proliferation of media messages that positively portray health-damaging behavior, and changing demographics resulting in increasing numbers of economically and educationally disadvantaged young people entering school (DHHS, 1996; National Commission on Children, 1991; Zill & Nord, 1994).

Changes in societal conditions and the changing behavior of our young people have prompted widespread calls for innovative family-, school-, and community-based prevention and health promotion approaches to address students' health and social needs (Carnegie Council on Adolescent Development, 1995; National Commission on the Role of the School and the Community in Improving Adolescent Health, 1990; Report of the National Mental Health Association Commission on the Prevention of Mental-Emotional Disabilities, 1986). In assessing the current functioning of children and their families, Dryfoos (1994) concluded that (a) a substantial percentage of young people will fail to grow into healthy, productive adults unless there are major changes in the way they are nurtured and educated; (b) although families and schools traditionally carried out the responsibilities for raising and educating children, they require transformation to fulfill these obligations more effectively; and (c) we need new types of community resources and services to support the development of children into responsible, healthy, fully contributing members of society.

The Role of *Healthy People 2010* in Establishing Effective Prevention Services for Young People

In 1979, the surgeon general published *Healthy People* (U.S. Department of Health, Education, and Welfare, Public Health Service, 1979), which summarized the nation's health accomplishments since 1900. *Healthy People* contended that further improvements in the health of Americans would require the widespread

implementation of effective health promotion and disease prevention strategies. In spite of considerable enthusiasm for the concept of prevention at the federal level during the 1970s, most professionals readily acknowledged the gap between prevention's potential and concrete record of performance. For example, in the foreword to *Primary Prevention: An Idea Whose Time Has Come*, Bertram Brown, then director of the National Institute of Mental Health, commented, "The lack of a sophisticated and comprehensive primary prevention program in mental health stands today as a major barrier between our present knowledge and resources and the goals this country has established for its mental health system" (1977, p. iii). Similarly, Emory Cowen (1977, p. 1) in "Baby-Steps Toward Primary Prevention" wrote:

> Kelly (1975) opened the First Vermont Conference on Primary Prevention with these words: "In my opinion, the topic of primary prevention is a most exciting and overdue challenge for psychology!" (p. 1). From the spinal cord—mine and others—the reaction to that statement is "Right on!" But, once past the initial surge of effusion and mutual backslapping often associated with the consensual validation of mushy abstract terms, several vexing facts surface: (a) agreeing with those words is a lot easier than doing decent primary prevention, [and] (b) however much the concept is pedestalized, it has, so far, done remarkably little to advance mental health.

The publication of *Healthy People* in 1979 and the *Report of the Task Panel on Prevention* (1978) marked a period of increased activity in prevention research and practice. A decade later, when the Office of Disease Prevention and Health Promotion (ODPHP) coordinated a broad-based national effort to develop a second report, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (DHHS, 1991), there was a growing research and practice literature on which to base recommendations for prevention and health promotion services. *Healthy People 2000* defined three overarching goals: to increase health across the life span, to reduce health disparities among Americans, and to achieve access to preventive services for all Americans.

Healthy People 2000 identified more than 300 health objectives, organized into 22 priority areas, to be accomplished by the year 2000. These objectives have guided health promotion and disease

prevention policies and programs at the federal, state, and local levels during the 1990s. The objectives were divided into three types (DHHS, 1991, p. 90):

1. Health status objectives to reduce death, disease, and disability
2. Risk reduction objectives to reduce the prevalence of risks to health or to increase behaviors known to reduce risk
3. Services and protection objectives to increase comprehensiveness, accessibility, and/or quality of preventive services and preventive interventions

It is the last set, the services and protection objectives, that is the focal point for this volume.

As comprehensive as *Healthy People 2000* is, the services and protection objectives do not go far enough toward addressing the needs of young people (American Medical Association, Department of Adolescent Health, 1990). One goal of this volume is to fill this gap through elaboration of salient threats to children's well-being and identification of promising preventive services. Our hope is that the ideas contained herein will contribute to the national discussion for *Healthy People 2010*. In this book and in its companion volume, *Healthy Children 2010: Enhancing Children's Wellness* (Weissberg et al., 1997), we strongly recommend that *Healthy People 2010* increase the number, specificity, and accuracy of child-focused service, prevention, and protection objectives related to children's mental health as well as their physical health and social functioning.

Establishing effective preventive services is a crucial aspect of changing the life course for those children at risk of failure. Investigators have developed several classification models for prevention (Cowen, 1983; Institute of Medicine, 1994). The most common terminology historically used for public health and preventive mental health includes the terms *primary prevention* and *secondary prevention* (Cowen, 1983). Primary prevention is dually focused on forestalling the development of psychological problems and enhancing people's psychosocial competence and health (Cowen, 1983). Primary prevention programs reduce the incidence of problems through group- or population-oriented interventions, rather than targeting individuals who exhibit behavioral and emo-

tional symptoms. They focus on well-functioning groups of people or those who, because of environmental circumstances or life events, are epidemiologically at risk for adverse psychological outcomes. Such programs are provided within the context of mainstream institutions, settings, and social policies rather than through specialized services for those manifesting psychological, social, or physical problems. In addition, primary prevention programs should be theoretically and empirically based, using information about risk and protective processes to increase the intervention's promise of promoting positive behavioral outcomes. Secondary prevention programs seek to reduce the prevalence or to lower the rates of established cases of disorder or illness in the population. They reduce the duration of a disorder through early case finding combined with prompt and effective intervention. One pathway to secondary prevention involves identifying behavioral or emotional symptoms of dysfunction early in someone's development and providing treatment to reduce the potential for later, more severe psychopathology. For our purposes, *establishing preventive services* involves both primary and secondary preventive services for mental, social, and physical health problems.

The Appendix lists all 46 *Healthy People 2000* services and protection objectives for children. These objectives focus primarily on five main topic areas:

1. Quality school health education
2. School readiness
3. Maternal and infant health
4. Primary care providers
5. State and federal policies

Although these objectives are positive steps, other crucial areas of need are sorely neglected. Some of the most notable gaps include (a) a lack of mental health service objectives (only Objective 6.14 begins to address this need); (b) a lack of attention to school-based prevention other than health education (e.g., school-based health clinics and primary preventive services such as screenings are not mentioned); (c) a lack of services to families (only Objectives 14.11-14.16 regarding maternal and infant health and Objective

7.15 regarding housing for battered women and their children address aspects of family life); and (d) a lack of comprehensive program strategies to enhance preschool children's readiness to succeed in school. We will elaborate on two issues to illustrate the type of critical thinking we hope will prevail as children's prevention service objectives for *Healthy People 2010* are established.

For example, Objective 6.3 in the Mental Health and Mental Disorders section recommends: "Reduce to less than 10 percent the prevalence of mental disorders among children and adolescents" (p. 211). The target for this objective was based, in part, on an inaccurate baseline estimate that 12% of young people under age 18 have mental disorders. The *Healthy People 2000: Midcourse Review and 1995 Revisions* (DHHS, 1995) changed Objective 6.3 as follows: "Reduce to less than 17 percent the prevalence of mental disorders among children and adolescents" (p. 191), based on an estimated baseline that actually 20% of young people have diagnosable mental disorders. Given the large numbers of young people experiencing mental health problems, it is striking that *Healthy People 2000* provides only one child-focused, secondary prevention services and protection objective (6.14), which states:

> Increase to at least 75 percent the proportion of providers of primary care for children who include assessment of cognitive, emotional, and parent-child functioning with appropriate counseling, referral, and follow up, in their clinical practice. (p. 219)

There are many other secondary and primary prevention services that could be recommended involving innovative family-, school-, and community-based preventive and competence enhancement programs. Chapters 2 to 6 of this volume present many promising directions.

Objective 8.4 provides another illustration that there is considerable room for improvement in describing issues related to implementation and evaluation of primary prevention programs. Specifically, Objective 8.4 recommends that the nation: "Increase to at least 75 percent the proportion of the Nation's elementary and secondary schools that provide planned and sequential kindergarten through 12th grade quality school health education" (p. 255). Beyond this core objective, there are many supplementary objectives encouraging—in the context of quality school health

education—a focus on nutrition; alcohol, tobacco, and other drugs; conflict resolution; injury prevention and control; HIV; and sexually transmitted diseases (McGinnis & DeGraw, 1991). Although we applaud this set of objectives, we note that according to the definition of quality school health education used in the *Healthy People 2000 Review, 1995-96* (National Center for Health Statistics, 1996), only 2.3% of schools actually provided all recommended components of quality school health education. Furthermore, concern has been expressed about emphasizing the inclusion of certain components in health education, such as conflict resolution, because current research has not documented the efficacy of this violence prevention approach (Murray et al., 1997).

Obviously, the well-being of young people requires and deserves greater attention from policymakers, service providers, and prevention researchers (Fleming, 1996). The intent of this volume is to spark discussion and debate among these groups about the most promising solutions and most effective methods for meeting these needs. This volume emphasizes the important contributions of various systems such as families, early childhood education, health clinics, and schools to the well-being of children. We suggest that the social, emotional, and physical needs of children and adolescents are best met through multiple and, ideally, coordinated systems. Furthermore, ensuring that we are using our best and most effective initiatives requires empirical program evaluation, strong implementation practices, and skilled dissemination efforts. We have encouraged the authors to elaborate on these concepts and to provide concrete objectives based on empirical research and field experience.

Summary of Chapters

Chapter 2: Policy Efforts to Enhance Child and Family Life: Goals for 2010 (Edward F. Zigler and Matia Finn-Stevenson)

Edward Zigler and Matia Finn-Stevenson present cogent arguments for integrating developmental research and social policy to improve the family life of children. After reviewing data about the

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changing conditions of family life and the powerful deleterious effects that stressful family circumstances have on children's mental health, they offer creative, family-centered recommendations for developing effective and family-friendly policy. The authors emphasize the importance of ensuring that our knowledge about effective programs is used and that workable, empirically based solutions to our pressing social problems are implemented through translation into public policy. They also draw attention to the need for family support services, an area sorely neglected in *Healthy People 2000*. Zigler and Finn-Stevenson use the issues of lack of quality child care and the effects of divorce as illustrations to describe obstacles in translating research into policy and offer suggestions for researchers, service providers, and policymakers to improve their collaborative efforts to make good social policy and program decisions.

Zigler and Finn-Stevenson describe their innovative School of the 21st Century, which calls for developing a more effective child care system within the already established educational system. The components in this model include parent education and support, including home visitations, from birth to age 3; all-day, year-round child care for 3- to 5-year-olds; before- and after-school and vacation care for children up to age 12; and health and nutrition education for parents and family day care providers. They contend that the School of the 21st Century can cost-effectively enhance coordination and resource sharing among existing school and community programs such as Head Start, other preschool and after-school services, and programs for children with special needs. The authors conclude with two major preventive service objectives for *Healthy People 2010*. The first is that all children would have access to good-quality child care; the second is that provisions be made to increase the availability of support services to families. In addition to being important in their own right, increasing preventive services in these areas would help the nation meet other health objectives such as reducing drug use (Dusenbury & Falco, 1997) or mental disorders (Compas et al., 1997; Kalafat, 1997) among children and youth. Currently, more than 400 schools in 13 states have implemented the School of the 21st Century. Greatly expanding that number by the year 2010 would foster improved health among young people well into the 21st century.

Chapter 3:
Defining and Implementing School Readiness: Challenges for Families, Early Care and Education, and Schools (Sharon L. Kagan and Michelle J. Neuman)

With the exception of maternal/infant health objectives, *Healthy People 2000* has only one service recommendation for children under age 5—Objective 8.3 states:

> Achieve for all disadvantaged children and children with disabilities access to high quality and developmentally appropriate preschool programs that help prepare children for school, thereby improving their prospects with regard to school performance, problem behaviors, and mental and physical health. (p. 254)

In their scholarly and visionary chapter, Sharon Kagan and Michelle Neuman challenge framers of *Healthy People 2010* to go beyond the limited recommendations for preschool children and families presented in *Healthy People 2000*. They stress the importance of understanding school readiness not simply as a child's readiness to learn or to benefit from formal schooling but also as family, school, and community readiness to meet the needs of each child. The authors offer a broad definition of *readiness* at the child level including five dimensions: physical health and motor development, social and emotional development, approaches toward learning, language usage, and general knowledge. Similar to Zigler and Finn-Stevenson, they emphasize the primary importance of families in shaping children's early development and learning.

Kagan and Neuman discuss parents' role in collaborating effectively with schools and communities to enhance their children's positive growth. They emphasize the need to establish early child care and family support systems that assist the development of families as a whole, as a normalized part of our social fabric, much as free public education has become a normalized social institution. From this perspective, readiness is not the burden of individual children (e.g., to know their numbers or ABCs) but is the shared responsibility of parents, schools, and communities. Kagan and Neuman contend that *Healthy People 2010* has the opportunity to focus more attention on the needs of young children by establishing

more, specific objectives that support readiness. They frame their prevention-service goals around three core messages: (a) conceptualize readiness as children's readiness, family readiness, school readiness, and community readiness; (b) generate adequate assessment systems for children, schools, and communities; and (c) consider children and families holistically. By building from the blueprints offered in Chapters 2 and 3, the authors of *Healthy People 2010* will be more likely to establish comprehensive, coordinated systems to affect tangibly children's growth and development during their important early years.

Chapter 4: Schools and the Enhancement of Children's Wellness: Some Opportunities and Some Limiting Factors (Emory L. Cowen)

Currently, there are too many children who experience social, emotional, and physical health problems, and there are not sufficient resources and personnel available to address these needs. Given the gap between the large number of children who require help and the limited services available, Emory Cowen asks, "What useful roles can schools play as part of a concerted social effort targeted to the enhancement of children's wellness?" (p. 98). He describes a variety of prevention methods including early detection and treatment programs for children showing beginning signs of maladjustment, establishing health promotion curricula, engineering health-enhancing school and class environments, and developing coordinated outreach systems to families and community settings. His vision requires a shift in focus from schools as "problem containers" to schools as "skill enhancers."

Cowen describes four decades of the Primary Mental Health Project (PMHP), an innovative, internationally renowned, secondary prevention, service-delivery model for the early detection and prevention of school maladjustment (Cowen, Hightower, Pedro-Carroll, Work, Wyman, & Haffey, 1996). PMHP has four structural components: (a) a focus on primary-grade children; (b) systematic screening for the early identification of children experiencing school maladjustment; (c) employing carefully selected, trained and supervised nonprofessional counselor assistants to provide direct

individual or small-group services to high-risk children; and (d) changing professional roles of school mental health professionals to reduce their direct service delivery in favor of increased participation in early screening, the training and supervision of counselor assistants, and consultation with teachers and other school personnel about cost-effective intervention strategies. PMHP is currently in more than 700 school districts nationally and exponentially increases the effective, helping services that schools can provide. As the authors of *Healthy People 2010* consider options for expanding the number of mental health services and protection objectives, increasing the number of schools that provide high-quality early detection and secondary prevention services for children should be given high priority.

The important secondary prevention service contributions of PMHP notwithstanding, Cowen also champions the critical importance of school-based primary prevention programming in addressing the question, "What could schools do to optimize the wellness and school adaptation of *all* children from the start, beyond targeting programs to the identifiable fraction at risk?" (p. 103). He identifies three core roles for school mental health professionals: (a) diagnosis and treatment for children with serious problems; (b) early detection and secondary prevention for at-risk children; and (c) primary prevention with emphases on competence promotion, the modification of class and school environments, and school-family-community partnerships to enhance wellness. He calls for major changes in the preparation and training of educators and mental health personnel laying the foundation for increased allocation of efforts to primary prevention and wellness enhancement service delivery.

Chapter 5: Mental Health Services for Children and Adolescents (Mary Jane Rotheram-Borus)

As mentioned previously, only one *Healthy People 2000* objective (6.14) targets children's mental health needs. Although Objective 6.14 expresses a worthy goal, it does not begin to address the full spectrum of children's mental health needs, nor does it acknowledge the importance of other nonclinical or nonmedical service

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providers in identifying and treating children's mental health problems. The true scope of problems experienced by children and the type and number of services involved are far larger and more complex than this service objective recognizes. Mary Jane Rotheram-Borus notes that "children with mental health problems are more likely to present in special education, foster care, primary health care, the juvenile justice system, and substance abuse treatment than in the mental health system" (p. 127). Furthermore, the needs, service pathways, and outcomes experienced by children depend in large part on structural characteristics of their communities (e.g., policy, financing, organization) as well as personal characteristics of the children and their families (e.g., age, gender, ethnicity, income). She outlines a theoretical model of factors that influence children's needs, access to and use of services, and treatment outcomes. This comprehensive model can help to frame future service objectives for meeting children's mental health needs.

In her review of the current state of service delivery to children, Rotheram-Borus elucidates the deleterious effects of the lack of coordination across programs and underscores the need for a more integrated approach. Troubled youth frequently have not just one problem, but many. Yet a lack of service coordination often means that although these youngsters may receive services of some sort, these services likely treat only parts of their problems. For example, juvenile justice may treat a youngster's violent behaviors, special education treats the learning disability, and a substance abuse treatment program handles the drug addiction. Furthermore, current social policies promote "sector shifting"; that is, the burden of care may be shifted from one agency to another based on cost, not on treatment needs. Thus, the type of care received may be based more on which agency can pick up the tab and less on what services are really needed. Such a disjointed and haphazard approach is neither economical nor optimally effective.

Rotheram-Borus recommends three central strategies in setting appropriate goals for 2010: (a) establish goals for communities, rather than the nation; (b) create a national surveillance system to monitor annually the implementation of the goals; and (c) link funding to the delivery of community-level outcomes to provide incentive and resources for communities to improve their delivery system. These strategies, combined with greater attention to issues

of access and dissemination of effective programs will enhance the likelihood of meeting children's mental health needs.

Chapter 6:
Improving Access to Health Care:
School-Based Health Centers (Shauna L. Dowden, Richard D. Calvert, Lisa Davis, and Thomas P. Gullotta)

The most frequently cited services and protection objective for children in *Healthy People 2000* invokes quality school health education (Objective 8.4). Many other objectives recommend particular components of school curricula that are ideally part of such a comprehensive educational program (see the Appendix). Although health education is an important part of attempts to reduce levels of risk among youth (Weissberg & Elias, 1993), it is not sufficient to meet the pressing health needs of many children. As several authors in this volume make clear, structural issues such as a lack of access to quality medical, mental, and social service programs as well as individual issues such as income and ethnicity interfere with healthy development, regardless of the amount of health education a child receives. Given the rising levels of drug and alcohol use, risky sexual behavior, and violence among youth, it is clear that many of the physical and emotional needs of children are not being met under the current patchwork of programs (described previously by Rotheram-Borus) designed to address isolated risk factors or problems. Finding workable solutions to these problems requires innovative use of current resources (e.g., schools) and development of new methods of service delivery.

In this chapter, Dowden and colleagues offer just such an imaginative and innovative comprehensive service delivery model. Their school-based alternative provides many potential benefits such as accessibility and economy without sacrificing quality and provision of service. In fact, their approach enhances service provision, particularly preventive care, to children and families. In many cases, the school-based health center may be a child or parent's only link to health care providers. Furthermore, housing medical, dental, and mental health services within a child's school greatly increases the likelihood of service integration and organization. Although, to date, there have been few evaluation studies on

the effectiveness of such an approach, these authors provide a clear rationale and concrete recommendations based on their own experiences in Connecticut.

Chapter 7:
Evaluation of Prevention Programs for Children
(Ernest Valente, Jr. and Kenneth A. Dodge)

The Institute of Medicine (1994) contends:

> There could be no wiser investment in our country than a commitment to foster the prevention of mental disorders and the promotion of mental health through rigorous research with the highest of methodological standards. Such a commitment would yield the potential for healthier lives for countless individuals and the general advancement of the nation's well-being. (p. 550)

Ernest Valente and Ken Dodge build and elaborate on this theme in their chapter by reviewing cutting-edge efforts in program evaluation and providing a set of comprehensive guidelines for evaluators. Good evaluation is important not only as a "score card" of progress but also for the generation of new theoretical understanding, better implementation practices, and improved dissemination of effective programs.

The Institute of Medicine (1994) identifies a five-stage sequence for prevention research: (a) identify a problem, review epidemiological data to determine its extent, and collaborate with communities to determine their level of concern about it; (b) identify risk and protect factors for the problem to understand its development; (c) design and conduct pilot efficacy trials and confirmatory replication trials to prevent the problem; (d) design, implement, and analyze large-scale preventive interventions; and (e) facilitate the dissemination, adoption, and ongoing evaluation of programs into community service settings. Valente and Dodge focus primarily on the formal evaluation of large-scale preventive interventions promoting positive mental health in young people—that is, the fourth stage in this sequence—but their detailed commentary has implications for all five stages. The program evaluation practices they endorse will (a) advance our theoretical understanding of how problem behaviors develop in young people, (b) measure and clarify the extent and quality of program implementation, (c) identify the most effective interventions to ensure that public health prevention efforts have maximum effect, (d) provide a base for more effective program dissemination, and (e) accurately document both the successes and limitations of preventive interventions with the goal of improving their quality over time. It is the widespread dissemination of effective prevention programs and strategies that will meaningfully enhance wellness and reduce problem behaviors among young people in future years.

Chapter 8:
Making Prevention Work (Denise C. Gottfredson, Carolyn M. Fink, Stacy Skroban, and Gary D. Gottfredson)

A fundamental premise of this volume is that preventive efforts are necessary to reduce risk factors and promote protective factors. However, not every prevention effort is created (or implemented) equal. The past few decades have seen a proliferation of prevention programs addressing a vast array of risk factors; some successfully, others not. In their chapter, Denise Gottfredson and colleagues explore some reasons why many school-based programs fail to achieve their goals. Interweaving relevant research findings in the prevention literature with observations based on their own experiences with a failed school-based prevention program, the authors summarize characteristics of programs and schools where innovative efforts are unlikely to succeed. For example, lack of technical training and ongoing support for implementation, the perception that the program is imposed by "outsiders" to the community or school, lack of leadership by key personnel within the school or school district, and general organizational incapacity greatly impair effective implementation of even the best programs. They emphasize that meeting the *Healthy People 2000* goal of providing quality school health education will require not only the development of good programs but also equally good program implementation skills. Their analysis of their own efforts to implement a comprehensive school-based health education program is a first step toward identifying common barriers to implementation

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and to reminding us that even the "best laid plans" require continuing attention and refinement.

Chapter 9: Reinterpreting Dissemination of Prevention Programs as Widespread Implementation With Effectiveness and Fidelity (Maurice J. Elias)

Although the importance of program dissemination is frequently acknowledged among program developers and evaluators, it is rarely a priority. Similarly, *Healthy People 2000* does not set goals or make recommendations for program dissemination—this aspect of service provision is routinely ignored. Demonstration programs and pilot projects, even good ones, often "wither on the vine" due to a lack of incentive or ability to disseminate. Maurice Elias provides a thoughtful analysis of dissemination issues that reveals their true importance for building prevention efforts that work.

Elias's focus is on ensuring that what we know works gets implemented in more than just the demonstration setting—that is, widespread implementation. He encourages us to consider the sources of energy and direction in getting good programs running—local people and initiative. His advice echoes that of Gottfredson and colleagues, that outsiders rarely create positive lasting change for communities. Although we can and should export programs that work, we must simultaneously respect the need for local citizens to create something that will work in their setting. Without the drive and enthusiasm of this next level of implementers, new programs are unlikely to flourish. In this sense, adhering strictly to what worked elsewhere may be less important than assisting communities to revise programs to meet their own unique needs. Elias makes the important point that a sense of ownership and contribution to the intervention is important not only for adults but also for the targeted children. Programs that involve their target audience in the intervention design are more likely to set appropriate and meaningful goals and thus are more likely to flourish than those that adhere to rigid criteria—that is, fidelity. Services and protection objectives for 2010 would do well to include incentives and goals for widespread implementation of effective and meaningful interventions.

Conclusions

A bare-bones list of recommendations culled from these chapters can hardly do justice to the depth and richness of ideas presented here. However, given the importance of these topics in addressing the health needs of children, we feel it appropriate to reiterate some of the most promising directions to pursue:

1. Improve accessibility of quality early childhood care and education through the development of an adequately funded infrastructure of services.
2. Use schools as the foundation for the provision of comprehensive services to children and parents, beginning in infancy and continuing until adulthood.
3. Encourage the development of school-family and school-community partnerships that target the welfare of all children.
4. Prepare educators to also be action researchers in their own schools, systematically assessing what works and what does not in their locations.
5. Encourage communities to set goals for themselves rather than attempt to set and reach national goals. Funding can be linked to attainment of community-level goals and administered through a national monitoring system.
6. An increase in the strength and quality of prevention programs, not simply the quantity, is crucial, particularly for those children most in need. Research on implementation and evaluation practices are necessary to ensure the delivery of quality programs.

Overall, the central message of this volume is the importance of striving to achieve a better balance of support systems that can improve children's health. This necessitates a much broader conceptualization of prevention and preventive services than that found in *Healthy People 2000*. It expands the circle of influence beyond just schools and primary care physicians to include roles for families, preschools, health clinics, youth clubs, businesses, communities, and policymakers—all of whom are essential players in improving services to children.

APPENDIX

Healthy People 2000 Services and Protection Objectives for Children

I. Quality School Health Education and Related Services

1.8 Increase to at least 50 percent the proportion of children and adolescents in 1st through 12th grade who participate in daily school physical education.

1.9 Increase to at least 50 percent the proportion of school physical education class time that students spend being physically active, preferably engaged in lifetime physical activities.

2.17 Increase to at least 90 percent the proportion of school lunch and breakfast services and child care food services with menus that are consistent with the nutrition principles in the Dietary Guidelines for America.

2.19 Increase to at least 75 percent the proportion of the Nation's schools that provide nutrition education from preschool through 12th grade, preferably as part of quality school health education.

3.10 Establish tobacco-free environments and include tobacco use prevention in the curricula of all elementary, middle, and secondary schools, preferably as part of quality school health education.

4.13 Provide to children in all school districts and private schools primary and secondary school educational programs on alcohol and other drugs, preferably as part of quality school health education.

5.8 Increase to at least 85 percent the proportion of people aged 10 through 18 who have discussed human sexuality, including values surrounding sexuality, with their parents and/or have received information through another parentally endorsed source, such as youth, school, or religious programs.

7.16 Increase to at least 50 percent the proportion of elementary and secondary schools that teach nonviolent conflict resolution skills, preferably as a part of quality school health education.

8.4 Increase to at least 75 percent the proportion of the Nation's elementary and secondary schools that provide planned and sequential kindergarten through 12th grade quality school health education.

8.9 Increase to at least 75 percent the proportion of people aged 10 and older who have discussed issues related to nutrition, physical activity, sexual behavior, tobacco, alcohol, other drugs, or safety with family members on at least one occasion during the preceding month.

9.18 Provide academic instruction on injury prevention and control, preferably as part of quality school health education, in at least 50 percent of public school systems (Grades K through 12).

18.10 Increase to at least 95 percent the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grade, preferably as part of quality school health education.

19.12 Include instruction in sexually transmitted disease transmission prevention in the curricula of all middle and secondary schools, preferably as part of quality school health education.

II. School Readiness

8.3 Achieve for all disadvantaged children and children with disabilities access to high-quality and developmentally appropriate preschool programs that help prepare children for school, thereby improving their prospects with regard to school performance, problem behaviors, and mental and physical health.

III. Maternal and Infant Health

14.11 Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy.

14.12 Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling.

14.13 Increase to at least 60 percent the proportion of women enrolled in prenatal care who are offered screening and counseling on prenatal detection of fetal abnormalities.

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14.14 Increase to at least 90 percent the proportion of pregnant women and infants who receive risk-appropriate care.

14.15 Increase to at least 95 percent the proportion of newborns screened by State-sponsored programs for genetic disorders and other disabling conditions and to 90 percent the proportion of newborns testing positive for disease who receive appropriate treatment.

14.16 Increase to at least 90 percent the proportion of babies aged 18 months and younger who receive recommended primary care services at the appropriate intervals.

17.15 Increase to at least 80 percent the proportion of providers of primary care for children who routinely refer or screen infants and children for impairments of vision, hearing, speech and language, and assess other developmental milestones as part of well-child care.

17.16 Reduce the average age at which children with significant hearing impairment are identified to no more than 12 months.

21.2 Increase to at least 50 percent the proportion of people who have received, as a minimum within the appropriate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the U.S. Preventive Services Task Force.

IV. Primary Care Providers

5.9 Increase to at least 90 percent the proportion of pregnancy counselors who offer positive, accurate information about adoption to their unmarried patients with unintended pregnancies.

5.10 Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling.

6.14 Increase to at least 75 percent the proportion of providers of primary care for children who include assessment of cognitive, emotional, and parent-child functioning, with appropriate counseling, referral, and follow up, in their clinical practices.

7.12 Extend protocols for routinely identifying, treating, and properly referring suicide attempters, victims of sexual

assault, and victims of spouse, elder, and child abuse to at least 90 percent of hospital emergency departments.

7.15 Reduce to less than 10 percent the proportion of battered women and their children turned away from emergency housing due to lack of space.

9.21 Increase to at least 50 percent the proportion of primary care providers who routinely provide age-appropriate counseling on safety precautions to prevent unintentional injury.

13.12 Increase to at least 90 percent the proportion of all children entering school programs for the first time who have received an oral health screening, referral, and follow up for necessary diagnostic, preventive, and treatment services.

V. State and Federal Policies

3.13 Enact and enforce in 50 States laws prohibiting the sale and distribution of tobacco products to youth younger than age 19.

3.14 Increase to 50 the number of States with plans to reduce tobacco use, especially among youth.

3.15 Eliminate or severely restrict all forms of tobacco product advertising and promotion to which youth younger than age 18 are likely to be exposed.

4.16 Increase to 50 the number of States that have enacted and enforce policies, beyond those in existence in 1989, to reduce access to alcoholic beverages by minors.

4.17 Increase to at least 20 the number of States that have enacted statutes to restrict promotion of alcoholic beverages that is focused principally on young audiences.

4.18 Extend to 50 States legal blood alcohol concentration tolerance levels of .04 percent for motor vehicle drivers aged 21 and older and .00 percent for those younger than age 21.

7.13 Extend to at least 45 States implementation of unexplained child death review systems.

7.14 Increase to at least 30 the number of States in which at least 50 percent of children identified as neglected or physically or sexually abused receive physical and mental evaluation with appropriate follow up as a means of breaking the intergenerational cycle of abuse.

9.14 Extend to 50 States laws requiring safety belt and motorcycle helmet use for all ages.

9.15 Enact in 50 States laws requiring that new handguns be designed to minimize the likelihood of discharge by children.

9.19 Extend requirements for the use of effective head, face, eye, and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation events that pose risk of injury.

13.15 Increase to at least 40 the number of States that have an effective system for recording and referring infants with cleft lips and/or palates to craniofacial anomaly teams.

17.20 Increase to 50 the number of States that have service systems for children with or at risk of chronic and disabling conditions, as required by Public Law 101-239.

20.13 Expand immunization laws for schools, preschools, and day care settings to all States for all antigens.

20.15 Improve financing and delivery of immunizations for children and adults so that virtually no American has a financial barrier to receiving recommended immunizations.

21.4 Improve financing and delivery of clinical preventive services so that virtually no American has a financial barrier to receiving, at a minimum, the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force.

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